REHAB PRE-ADMISSION FORM:

Elective Hip and Knee Surgery - Replacements and Revisions

The information contained herein is confidential. No unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker.

Patient: Last name: ______________________ First name: ______________________

Health Card: Number: ______________________ Version: _____ **Date of Birth:** Y/ ____ M/____ D/____

Gender: ❑ Male ❑ Female **Height:** _________ ❑ unknown **Weight >250lb/113 kg:** ❑ Yes ❑ No ❑ Unknown

Address: ______________________City____________Postal Code:__________

Home Phone Number: (   ) ______________ **Accommodation Requested:** ❑ Standard ❑ Semi-Private ❑ Private

Insurance Company______________________Policy certificate/group #______________

Next of Kin/Emergency Contact: Name: ______________________Telephone: ______________

Current Surgical Intervention:

	Hip Replacement	Knee Replacement	Revision of Hip Implant	Revision of Knee Implant	Pin and Plate	Hemiarthroplasty
Right	❑	❑	❑	❑	❑	❑
Left	❑	❑	❑	❑	❑	❑

Other (specify):______________________

Primary Diagnosis:
❑ Unknown ❑ Osteoarthritis (right) ❑ Osteoarthritis (left) ❑ AVN ❑ RA ❑ Other: ______________________

Secondary Diagnoses *(check all that apply)*
❑ Unknown
❑ Stroke/Acquired Brain Injury
❑ Diabetes Milletus
❑ Hypertension
❑ Cardiac *(specify)*______________________
❑ Respiratory *(specify)*______________________
❑ Other *(specify)*______________________

Language spoken *(if not English)*: ______________ **Interpreter required:** ❑ Yes ❑ No ❑ Unknown

Living Setting:

Prehospital:	home ❑	community ❑	facility ❑
Discharge:	home ❑	community ❑	facility ❑

Have discharge plans been discussed? ❑ Yes ❑ No

Past and relevant history:
Psychiatric: ❑ Unknown ❑ No ❑ Yes *(specify)*______________________
____
Medical: ❑ Unknown ❑ No ❑ Yes *(specify)*______________________
____
Surgical: ❑ Unknown ❑ No ❑ Yes *(specify)*______________ Y/ _____ M/_____D/_____ ____

Other Notes:______________________
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Date of Surgery:	Y/ ________	M/__________	D/__________	❑ Date Unknown
Date of Referral:	Y/ ________	M/__________	D/__________	❑ Date Unknown
Date Ready for Rehab/Self Care	Y/ ________	M/__________	D/__________	❑ Date Unknown

Physician/specialists involved in care of patient:
Name:______________ Specialty: ______________ Phone: (   )__________
Name:______________ Specialty: ______________ Phone: (   )__________
Name:______________ Specialty: ______________ Phone: (   )__________

Contact person: ______________________ Phone: (   ) __________
Position:______________ Organization______________ Pager: (   ) __________